Understanding HCTC-Basic Health

Before you apply for HCTC-Basic Health, you should already know you are potentially eligible for the federal Health Coverage Tax Credit. For more information, visit the HCTC Web site at www.irs.gov (keyword: HCTC) or call their Customer Contact Center at 1-866-628-4282.

The Health Coverage Tax Credit (HCTC) is a federal tax credit that pays 65% of the health plan premium for eligible people enrolled in qualified health plans. Eligible individuals can claim it in advance to help pay for health plan premiums as they become due.

HCTC-Basic Health is generally for people who are:

- Displaced workers who receive Trade Readjustment Allowances (TRA) under the Trade Adjustment Assistance (TAA) Act.
- Some individuals who received pension benefits from the Pension Benefit Guaranty Corporation (PBGC).

If you think you are eligible for the HCTC, please visit www.irs.gov (keyword: HCTC) or call the HCTC Customer Contact Center at 1-866-628-4282 (TTY: 1-866-626-4282), 5 a.m. to 5 p.m. Pacific Standard Time.

In Washington State, Basic Health is a "qualified health plan" for HCTC coverage. The U.S. Department of the Treasury (Internal Revenue Service) administers the HCTC program in partnership with other federal agencies, the states, and the private health industry.

Cost

- Monthly premiums are based on age, number of family members enrolled, health plan chosen, and the county where you will receive services
- Low copayments
- $150 annual deductible
- 20% coinsurance
- $1,500 annual out-of-pocket maximum

Choice of provider

- Select your own doctor or other provider affiliated with the health plan you choose
- Choice of health plans in most counties
- Decide on the health plan that offers the best value, location, and providers for you

Benefits

- Doctor and hospital care, including preventive care
- Emergency services
- Prescription drugs

Overview

Deadlines

If you qualify for HCTC coverage, you have a limited window in which to enroll in Basic Health.

If you are enrolled in HCTC-Basic Health, you may be affected by preexisting conditions exclusions (see *Member Handbook*, which you will receive once enrolled, for details; it is also available on the Basic Health Web site: www.basichealth.hca.wa.gov/forms.shtml). However, the nine-month waiting period for treatment of preexisting conditions will be waived if you had at least three months of creditable coverage prior to enrolling in Basic Health, with no more than a 62-day break in coverage at the time of application. If you had a break in coverage of 63 days or more, or if you did not have three months of creditable coverage, the nine-month waiting period will apply the same as for all other Basic Health members. For the purposes of the HCTC, creditable coverage includes a group health plan (including COBRA, Temporary Continuation of Coverage [TCC], or state continuation coverage) or health insurance (including individual coverage, college or school insurance, or short-term limited duration insurance).

Claiming the Health Coverage Tax Credit

If you are eligible for the Health Coverage Tax Credit, you may either:

- Claim the credit in advance to help pay your monthly HCTC-Basic Health premiums; or
- Claim the credit on your federal income tax return.

Your monthly HCTC-Basic Health premium

Your HCTC-Basic Health premium is based on the age of covered family members, the health plan you choose, and the county where you get health care services. Your premium also includes an administrative fee.

Paying for your coverage

If you choose to claim the credit in advance, you will receive a bill from the Internal Review Service (IRS) each month for your share of the premium. You must pay that bill, then the IRS will pay Basic Health the full cost of your coverage. Basic Health cannot accept your direct payment before you're enrolled in HCTC-Basic Health.

If you do not pay your share of the premium to the IRS by the due date they give you, the IRS will not pay your HCTC-Basic Health premium; you will lose coverage for one month. **Please note**: If this happens, you may be able to pay your entire premium yourself for up to two months, or you may be eligible for our subsidized Basic Health program. Contact Basic Health for details.

Cost-sharing responsibilities

Each Basic Health member is responsible for sharing the cost of his or her health care coverage. Cost sharing comes in the form of copays, coinsurance, and deductibles. In addition, each member will have an out-of-pocket maximum, as explained on page 4.

If a Basic Health member changes health plans any time during the year, the amount paid toward the deductible and out-of-pocket maximum for covered family members will start over with the new health plan.

After you send in your HCTC-Basic Health application

HCTC-Basic Health processes applications on a first-come, first-served basis. “Processing” means that a Basic Health staff member will review your application and HCTC candidate letter. We will then generate an enrollment letter, which includes notice of your monthly premium. You should send that letter on to the HCTC program (be sure to keep a copy); they will send a bill to you for the percentage you owe them. Once you have paid the HCTC program your portion, they will pay your Basic Health premium.

Once enrolled in HCTC-Basic Health, the health plan you choose will send identification (I.D.) cards for you and your enrolled family members. Some health plans may require that you choose a primary care provider before they will issue your I.D. card. The confirmation letter you receive from Basic Health can serve as temporary identification until you receive your card.

On an ongoing basis, you are responsible for letting us know if there are changes to your address or enrolled family members. You will receive a *Basic Health Member Handbook* after your coverage begins; it will explain the details.

Definitions

Copay

A set dollar amount you pay when receiving specific services or treatments. In most cases, this will be $15, except for prescription drugs and emergency room visits (see page 10). Copays do not apply to your deductible, coinsurance, or out-of-pocket maximum. The following are copays you will be responsible for in 2008:

Office visit:	$ 15
Prescription drugs	
Tier 1:	$ 10
Tier 2:	50% of the drug cost
Emergency room visit:	$100

Deductible

The amount you pay before your health plan starts to pay for certain covered services. In 2008, you will be responsible for paying the first $150 of certain covered medical costs before your health plan pays 80% of the covered services. The $150 annual deductible must be met for each family member enrolled in HCTC-Basic Health. The deductible does not apply towards the annual out-of-pocket maximum. If you change plans any time during the year, the amount you’ve paid toward your deductible for covered family members will start over with your new health plan.

Coinsurance

The percentage you pay when your health plan pays less than 100% for covered services. Your health plan will not pay toward services with a coinsurance until you have paid your $150 annual deductible. In 2008, you will be responsible for paying 20% of the cost for services that have a coinsurance. Your health plan pays the remaining 80%.

Out-of-pocket maximum

Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you or another covered family member reaches the out-of-pocket maximum, you are not responsible for any further coinsurance costs for covered services received by that person during the year. Your health plan will pay 100% of all coinsurance costs. However, you will still be required to pay applicable copayments.

Explanation of benefits (EOB)

Each time you receive medical services, you will be sent a detailed statement from your health plan that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you pay.

How the health plans work

On our HCTC-Basic Health application, you must choose a health plan where indicated.

Basic Health contracts with health plans all over Washington State to provide health care coverage to those eligible for the Health Coverage Tax Credit. All health plans in Basic Health offer the same basic benefits, but monthly premiums, providers, and some details of coverage vary (such as which prescription drugs or preventive services are covered).

The health plans require each Basic Health member to select a primary care provider (PCP). To receive benefits, you must receive care from your health plan's authorized providers. Your PCP may provide or coordinate your care. Each covered family member may have a different PCP. If you don't choose a PCP, your health plan may choose one for you. You may change your PCP during the year. Contact the health plan for more information on changing a PCP or for a current list of providers.

In an emergency, you may receive Basic Health benefits for care without prior PCP approval. However, you must report this to your primary care provider or health plan within 24 hours or as soon as possible. In addition, women may self-refer to a plan-designated women's health care professional for medically necessary services or medically appropriate follow-up maternity care, routine gynecological exams, and reproductive care. Check with your health plan for details.

Your health plan may require pre-approval of some services. If you receive care that is not covered under Basic Health, you must pay the entire cost for those services.

Choosing a health plan

Think about the following things when choosing a health plan. If you have questions or need specific information, call the health plan directly.

Benefits

All health plans in Basic Health offer the same basic benefits, but monthly premiums, providers, and some details of coverage may vary (such as which prescription drugs or preventive services are covered).

Prescription drugs

If you take medications regularly, ask the health plan if it covers those prescriptions. Health plans do not all cover the same prescriptions.

Doctors or other providers

Be sure to consider your choice of providers (doctors, clinics, hospitals, pharmacies, and other health care professionals) as well as monthly premium. Your current provider, or the providers nearest to you, may not contract with the lowest-cost health plan.

If you have Internet access, visit our Web site at www.basichealth.hca.wa.gov or the health plans' Web sites (listed on page 12) for provider listings. If you have a specific provider you would like to see, ask if (s)he will be participating with Basic Health and the health plan you've chosen in 2007. You should also confirm this with the health plan.

Provider groups

Some health plans may contract with provider groups, called subnetworks; this may limit your choice of providers. You may be required to see specialists or use facilities, such as hospitals, which are in the same subnetwork as your PCP. This means that even if a provider is listed with your health plan, the provider's services may not be available to you unless the provider is also affiliated with your PCP. Call the health plan or your PCP to find out if your PCP can refer you to anyone listed as a provider with that health plan, or if your PCP can refer you to only a selected group of providers within the health plan.

Health plan availability by county

	Columbia United Providers	Community Health Plan of Washington	Group Health Cooperative	Kaiser Permanente	Molina
Adams		X			X
Asotin					X
Benton		X			
Chelan		X			X
Clallam					X
Clark	X	X			
Columbia					X
Cowlitz		X		X	
Douglas		X			X
Ferry		X			X
Franklin		X			
Garfield					X
Grant		X			X
Grays Harbor		X			X
Island		X			
Jefferson		X			
King		X	X		X
Kitsap		X	X		
Kittitas					X
Klickitat		X			
Lewis		X			X
Lincoln		X			X
Mason		X			
Okanogan		X			X
Pacific		X			X
Pend Oreille		X			X
Pierce		X			X
San Juan		X			
Skagit		X			
Skamania		X			
Snohomish		X	X		
Spokane		X	X		X
Stevens		X			X
Thurston		X	X		X
Wahkiakum		X			
Walla Walla		X			X
Whatcom		X			X
Whitman					X
Yakima		X			X

Health plans and HCTC full monthly premiums, by county

Health Plan	**Columbia United Providers**	**Community Health Plan of WA**					**Group Health Cooperative**		
County Where You Live	Clark	Adams Benton Chelan Douglas Ferry Franklin Grant Lincoln Okanogan Pend Oreille Skagit Stevens Whatcom	Clark Grays Harbor Jefferson Klickitat Lewis Pierce Skamania Thurston Wahkiakum	Cowlitz Mason Pacific	Kitsap Snohomish	Island King San Juan Spokane Walla Walla Yakima	King Spokane	Kitsap Snohomish	Thurston
Age									
One Child	$102.50	$94.35	$102.50	$106.85	$98.33	$89.93	$89.93	$98.33	$102.50
2 Children	$205.00	$188.70	$205.00	$213.70	$196.66	$179.86	$179.86	$196.66	$205.00
3+ Children	$307.50	$283.05	$307.50	$320.55	$294.99	$269.79	$269.79	$294.99	$307.50
0-39*	$232.09	$214.42	$232.09	$241.52	$223.04	$204.85	$204.85	$223.04	$232.09
40-54	$294.72	$272.07	$294.72	$306.82	$283.13	$259.81	$259.81	$283.13	$294.72
55-64	$496.88	$458.14	$496.88	$517.56	$477.06	$437.17	$437.17	$477.06	$496.88
65+	$625.00	$576.07	$625.00	$651.12	$599.97	$549.58	$549.58	$599.97	$625.00

*An individual under age 19 who is the main subscriber or spouse will pay the age 19-39 premium.

Health Plan	**Kaiser Permanente**	**Molina**				
County Where You Live **Age**	Cowlitz	Adams Chelan Douglas Ferry Grant Lincoln Okanogan Pend Oreille Stevens Whatcom Whitman	Asotin Columbia Garfield Pacific	Clallam	Grays Harbor Lewis Pierce Thurston	King Kittitas Spokane Walla Walla Yakima
One Child	$117.87	$94.35	$106.85	$105.07	$102.50	$89.93
2 Children	$235.74	$188.70	$213.70	$210.14	$205.00	$179.86
3+ Children	$353.61	$283.05	$320.55	$315.21	$307.50	$269.79
0-39*	$265.39	$214.42	$241.52	$237.66	$232.09	$204.85
40-54	$337.43	$272.07	$306.82	$301.87	$294.72	$259.81
55-64	$569.90	$458.14	$517.56	$509.09	$496.88	$437.17
65+	$717.25	$576.07	$651.12	$640.43	$625.00	$549.58

2008 Basic Health benefits and services

Benefits and services NOT subject to the deductible and coinsurance

The $150 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year **DO NOT** apply to the following benefits and services.

Benefit/service	Member's payment responsibility	Notes
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*	 Tier 1 - $10 copay Tier 2 – 50% of the drug cost	30-day supply Tier 1 includes generic drugs in health plan's preferred drug list (formulary). Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance apply to all other services.
Skilled nursing, hospice, and home health care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	HCTC-Basic Health will cover maternity benefits in full.
Oxygen	No copay	Includes equipment and supplies. Not subject to copays, coinsurance, or deductible. Requires health plan authorization.

*Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must first pay your $150 annual deductible. Once you meet your $150 deductible, all coinsurance payments will be applied toward your $1,500 out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services listed on page 4. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/service	Member's payment responsibility	Notes
Hospital, inpatient **Hospital, outpatient**	20% coinsurance; deductible applies. $300 maximum facility charge per admittance. 20% coinsurance; deductible applies	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. See "Other professional services" below.
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count towards 12-visit maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/physical therapy/occupational therapy	20% coinsurance; deductible applies	Up to a combined maximum of 12 visits per year. (Of those, no more than six can be for chiropractic care.) Visits qualify only when used as post-operative treatment following reconstructive joint surgery. Visits must be within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient $300 maximum facility charge per admittance	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Organ transplants	Deductible, coinsurance, and copays apply by specific service	12-month waiting period, except for newborns or for a condition that is not preexisting.

Basic Health exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Sleep studies, except the initial sleep study authorized by the contracted health plan. Only one sleep study per member per calendar year is covered.
9. Transportation except as specified under "Organ transplants" and "Emergency care."
10. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
11. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
12. Sex change operations.
13. Investigation of a treatment for infertility or impotence.
14. Reversal of sterilization.
15. Artificial insemination.
16. In-vitro fertilization.
17. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
18. Hearing aids.
19. Orthopedic shoes and routine foot care.
20. Speech and recreation therapy.
21. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
22. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (including, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
23. Weight loss programs.
24. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise noted in the "Schedule of Benefits."
25. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
26. Conditions resulting from acts of war (declared or not).
27. Direct complications arising from excluded services.
28. Replacement of lost or stolen medications.
29. Evaluation and treatment of learning disabilities, including dyslexia.
30. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

Health plan contact information

The contact information below is for the health plans that contract with Basic Health and offer coverage to HCTC-Basic Health members. Health plan information in this document is believed to be accurate and current, but be sure to confirm data before making decisions.

	Customer service hours	Customer service phone numbers	Web site address
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962	www.cuphealth.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 TTY/TDD: 1-800-833-6388	www.chpw.org
Group Health Cooperative	Mon. – Fri. 8 a.m. – 5 p.m.	1-888-901-4636 TTY: 1-800-833-6388	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-813-2000 TTY: 1-800-324-8010	www.kaiserpermanente.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 5:30 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com